

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155687</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/27/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER-MUNCIE</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>2701 LYN-MAR DR</b> <b>MUNCIE, IN 47304</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaint IN00114489.</p> <p>This visit was done in conjunction with the Recertification and State Licensure Survey and the Investigation of Complaint IN00112143.</p> <p>Complaint IN00114489 - Unsubstantiated, due to lack of evidence.</p> <p>Survey dates: August 20, 21, 22, 23, 24, and 27, 2012</p> <p>Facility number: 000097 Provider number: 155687 AIM number: 100290970</p> <p>Survey team: Betty Retherford RN, TC Julie Call RN Virginia Terveer RN</p> <p>Census bed type: SNF/NF: 100 Total: 100</p> <p>Census payor type: Medicare: 11 Medicaid: 79 Other: 10 Total: 100</p> <p>Sample: 7</p> <p>Golden Living Center-Muncie was found to be in compliance with 42 CFR part 483, subpart B and 410 IAC 16.2 in regard to the Investigation of</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155687</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/27/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER-MUNCIE</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>2701 LYN-MAR DR</b> <b>MUNCIE, IN 47304</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	Continued From page 1 Complaint IN00114489.  Quality review 8/30/12 by Suzanne Williams, RN			F 000			